inessential to the term's definition, and therefore not pertinent to our argument. The readiness of reproduction being equated with differentiation and market elasticity are loosely stated principles of economics, not the definition of commodity. Reducing medical care to the status of a commodity, the objection we find in boutique medicine, makes the practice of medicine a purely commercial transaction. Whether that transaction involves a differentiated or undifferentiated good or service is ethically irrelevant to our argument that doing so undermines medical professionalism.

Our article did not predict a 2-tiered medical system emerging from the boutique model; we did intimate that it could result in a 2-tiered individual practice among physicians who adopt it. Our objection to this is that it would result in physicians who engage in boutique medicine treating the rich and poor differently, which, Dr Gregory pointed out more than 2 centuries ago, violates fiduciary professionalism. VIP medicine is arranged and administered by the individual physician; the tiers are within his practice. The easier access and closer observation he provides his premium-fee patients necessarily means that all other patientss are receiving less than his best efforts and attention. A multitiered medical *system* follows when these individual practices grease the slope toward normalization of socially acceptable multitiered insurance benefits, perhaps a boutique policy for the company's top executives and a "standard plan" for the folks on the assembly line. The quality, quantity, and accessibility of medical care may show a normal range of variation consistent with skills and resources from 1 institution or physician to another. The systemization of these variations becomes unethical, however, when they occur within a structure that offers the physician special incentives to stratify the quality of care on the basis of the patient's ability to pay, or willingness to pay an inflated premium, as in our boutique model. Drs Akbari and Henochowicz conclude that boutique medicine is ethically neutral, with doctors merely attempting "to differentiate themselves in the marketplace by providing perceived specialized services."

Boutique medicine does not differentiate the physicians, it differentiates the patients—and in so doing becomes ethically unpalatable. Drs Akbari and Henochowicz prefer "concierge" to "boutique" medicine. Neither of these terms of commerce reflects the special responsibilities of the medical professional, or the absolute trust with which every patient approaches his physician. Drs Akbari and Henochowicz have accurately described a "commodity" in economic discourse; if physicians begin to associate it with their patients, the "medical profession" will become an oxymoron.

James W. Jones, MD, PhD
Laurence B. McCullough, PhD

Baylor College of Medicine
Houston, Tex

Bruce W. Richman, MA

University of Missouri
Columbia, Mo

REFERENCE

1. Shipley J. Dictionary of word origins. New York: Dorset Press; 1075.

doi:10.1016/j.jvs.2004.07.018

Regarding "Standards of practice: Carotid angioplasty and stenting"

We appreciate Ouriel et al's commentary (J Vasc Surg 2004; 39:916-7) highlighting the quality improvement guidelines for the performance of cervical carotid angioplasty and stent placement.[1]

We wish to clarify that the radiology guidelines provide a training pathway for physicians with experience sufficient to meet the American Heart Association requirements for peripheral vascular interventions, this being prior experience of 100 diagnostic cervicocerebral angiograms with documented acceptable indications and outcomes.[1,2] In agreement with previous recommendations by the American Heart Association, regardless of the number of angiograms in another vascular bed, each vascular bed is distinct and 100 angiograms are necessary.[2]

We agree with the authors that carotid stenting is a dynamic area. As stated in our guidelines, the document was developed on the basis of evidence-based literature. As additional peer-reviewed studies are published, we look forward to working with all interested specialties to refine these guidelines in order to ensure excellence in patient care. We have long recognized the valuable impact that multidisciplinary documents have in the improvement of patient safety and patient care outcomes.

We agree that clinical trial data are important for evaluating new technology. However, as noted in the commentary of Ouriel et al., some procedures prematurely become widely accepted before convincing evidence is available. In these circumstances, a consensus statement summarizing the available evidence-based recommendations for treatment is valuable. For example, experience has demonstrated that while benefit seemed "intuitively clear" for extracranial-intracranial bypass surgery for carotid and intracranial atherosclerosis, true clinical trial data led to the demise of this procedure.[3] Additionally, for 4 decades warfarin was "thought to be" the "maximum medical therapy" for cerebrovascular disease, but it was then proven that aspirin was as good as or better than warfarin.[4,5]

The Society of Interventional Radiology and the American Society of Interventional and Therapeutic Neuroradiology are committed to working with industry and government to ensure that appropriately selected patients have access to this beneficial new technology. In addition to guideline development, we will work with other specialties to ensure future coverage by Centers for Medicare and Medicaid Services. We look forward to working with all those involved in carotid stenting to further develop and evaluate this important new technology.

Janette D. Durham, MD, MBA

President, Society of Interventional Radiology
University of Colorado Health Sciences Center
Denver, Colo

David Sacks, MD

Standards Division Councilor, Society of Interventional Radiology
Reading Hospital
Reading, Pa

John J. Connors III, MD

President, American Society of Interventional and Therapeutic Neuroradiology
Miami Cardiac and Vascular Institute
Miami, Fla

REFERENCES

1. Barr JD, Connors JJ III, Sacks D, Wojak JC, Becker GJ, Cardella JF, et al. Quality improvement guidelines for the performance of cervical carotid angioplasty and stent placement. Developed by a collaborative panel of the American Society of Interventional and Therapeutic Neuroradiology, the American Society of Neuroradiology, and the Society of Interventional Radiology. J Vasc Interv Radiol 2003;14:1079-93.
2. Levin DC, Becker GJ, Dorros G, Goldstone J, King SB 3rd, Seeger JM, et al. Training standards for physicians performing peripheral angioplasty and other percutaneous peripheral vascular interventions. A statement for health professionals from the Special Group of Councils on Cardiovascular Radiology, Cardio-Thoracic and Vascular Surgery, and Clinical Cardiology, American Heart Association. Circulation 1992;86:1348-50.

3. The EC/IC Bypass Study Group: failure of extra-intracranial arterial bypass to reduce the risk of ischemic stroke: results of an international randomized trial. N Engl J Med 1985;313:1191-1200.
4. Mohr JP, Thompson JLP, Lazar RM, Levin B, Sacco RL, Furie KL, et al, for the Warfarin–Aspirin Recurrent Stroke Study Group. A comparison of warfarin and aspirin for the prevention of recurrent ischemic stroke. N Engl J Med 2001;345:1444-51.
5. Chimowitz M, for the WASID investigators. Warfarin versus aspirin for symptomatic intracranial disease. San Diego: American Society of Anesthesiology; 2004.

doi:10.1016/j.jvs.2004.07.019

Reply

It is interesting to note that there exist few differences in opinion between the radiology and surgery groups. We have more in common than we are at variance. The 2 specialty groups seek to collect data on novel technology, systematically analyze the information, and provide recommendations to governmental regulatory agencies. The analysis of available data does not differ substantially; both specialties agree that there is now ample evidence to recommend approval of and funding for carotid stenting in selected, appropriate patients.

The 1 area of remaining contention relates to the requirement that carotid angiography be part of the training paradigm for stenting. The radiologists identify a minimum of 100 diagnostic carotid angiograms prior to initiating training in carotid stenting. By contrast, the surgical and cardiology societies believe that experience in cerebral angiography, while a necessary prerequisite to carotid stenting, should be much more limited. Of note, the authors of the letter incorrectly state that the 1992 AHA training document for peripheral angioplasty specifies 100 angiograms in each vascular bed as a prerequisite for peripheral interventions. Review of the AHA document reveals the following statement on privileging: "[Training] must include performance of 100 diagnostic peripheral angiograms and 50 renal and/or peripheral percutaneous transluminal angioplasty [sic], and for at least half of these procedures the applicant must be primary operator."[1]

The document never states that "each vascular bed is distinct," nor does it suggest that 100 procedures must be performed in each bed.

At the heart of this controversy, diagnostic carotid angiography is a procedure performed in diminishing numbers in an era where duplex ultrasound and magnetic resonance angiography have achieved a high level of diagnostic accuracy. Further, the skills involved in carotid angiography represent but a small subset of those skills necessary to safely deliver and deploy a carotid stent. Noting these limitations, the surgeons and cardiologists now advocate a much smaller number of prerequisite carotid angiograms; on the order of 30.

The radiology groups' declared commitment to join in the quest for approval and funding for carotid stenting provides optimism for the near-term availability of carotid stenting in appropriate candidates.

Kenneth Ouriel, MD

Chair, Surgery
The Cleveland Clinic Foundation
Cleveland, Ohio

REFERENCE

1. Levin DC, Becker GJ, Dorros G, Goldstone J, King SB 3rd, Seeger JM, et al. Training standards for physicians performing peripheral angioplasty and other percutaneous peripheral vascular interventions. A statement for health professionals from the Special Group of Councils on Cardiovascular Radiology, Cardio-Thoracic and Vascular Surgery, and Clinical Cardiology, American Heart Association. Circulation 1992;86:1348-1350.

doi:10.1016/j.jvs.2004.07.020